DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

June 10, 1996

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 96-32

SAWYER POLICY AND PROCEDURES: PHASE II

Ref.: All County Welfare Directors Letter (ACWDL) No. 95-63

SECTION I. INTRODUCTION

History of the Sawyer Litigation: Since the inception of the Medi-Cal program, the Department of Health Services (DHS) has interpreted federal Medicaid law as requiring Worker's Compensation temporary disability indemnity (TDI) payments to be counted as unearned income. These payments will be referred to throughout these instructions as Temporary Worker's Compensation payments (TWC). In 1994, the Sawyer lawsuit was filed against DHS and the Department of Social Services (DSS) for the purpose of changing DHS and DSS policy to one of counting TWC payments as earned income. During the pendency of this litigation, the federal Aid to Families with Dependent Children (AFDC) administrator reinterpreted its AFDC-eligibility rules to require that TWC be counted as earned income in those instances where the TWC recipient continued to be employed by the employer for whom he/she was working when the injury was incurred. In accordance with federal law, which requires the application of many of the AFDC eligibility rules to certain categories of Medi-Cal eligibles, Medi-Cal is applying the four AFDC-MN and MI earned income deductions to its AFDC-MN and MI persons.

SECTION II. OVERVIEW

Overview Of Sawyer Second Phase II Implementation: This ACWDL implements Phase II of the Sawyer benefit. Under this ACWDL, counties will evaluate cases which are identified through Sawyer Applications submitted by persons during the August 1, 1996 through October 31, 1996 application period who are responding to posted Sawyer Notices (Poster Notices). The purpose of this Phase II reimbursement is to identify and reimburse qualified cases not previously identified and reimbursed through the flagging and Quarterly Status Report process established under ACWDL 95-63.

Under this ACWDL, counties will evaluate qualified cases (see definition, Section III) identified through Sawyer Reimbursement Applications submitted by former or current beneficiaries responding to the Sawyer Poster Notices. The procedure for evaluating cases, converting case budgets, and calculating reimbursements is the same as that set forth in ACWDL 95-63 and is reiterated in this ACWDL. After the reimbursement for a case has been calculated, counties will complete a Sawyer Reimbursement Request (Exhibit A) and transmit it to DHS. DHS will issue a reimbursement check, and an accompanying notice, to the reimbursee.

Summary of Previously Issued Sawyer Policy: Under the previous Sawyer policy letter, ACWDL 95-63, new and continuing qualified cases identified via the Quarterly Status Reports or the flagging process (ACWDL 94-49) had their share of cost (SOC) calculated for prospective months to reflect that TWC was earned income. Qualified, continuing and discontinued cases having received TWC in or after May 1994 were evaluated for reimbursement for the months within the Sawyer Reimbursement Period, and, if determined eligible, were reimbursed.

SECTION III. DEFINITIONS

Qualifying Temporary Worker's Compensation Payments: Under the terms of the settlement agreement, TWC qualifies as earned income when verified TWC is received by an AFDC-MN or MI person in a Qualified Case.

Qualified Case: For purposes of determining eligibility for the reimbursement described in this ACWDL, a case is a qualified case for any month from July 1992 through April 1994 (first retroactive period) in which (1) an eligible or ineligible AFDC MN or MI person in the case Medi-Cal Family Budget Unit (MFBU) received verified TWC, 2) the case had, and was certified as having met (see Section IX, subheading "Medical Expense Verification"), its pre-Sawyer SOC, and 3) the case was not previously identified and evaluated for reimbursement under ACWDL 95-63. The case must first be an identified case: a case for which the county has received a properly completed Sawyer application from an eligible or ineligible member of an MFBU.

Individuals receiving TWC who are on Medi-Cal as ABD-MN persons do not have their TWC counted as earned income, and a case containing such a person and no AFDC-MN or MI person with TWC is not a qualified case. Qualified cases must be evaluated under this ACWDL to determine whether they are eligible for a reimbursement.

If the county determines that a case will receive a reimbursement under this ACWDL during the first retroactive period, then that case also must be evaluated to determine whether it is a

qualified case in any months from January 1991 through June 1992 (second retroactive period.) In making this determination, the county is not required to seek additional documentation or verification, but may use what is present in the case file or has already been obtained from the applicant.

Reimbursement Period (Reimbursement Period): This period is composed of two periods, the first retroactive period, July 1992 through April 1994, and the second retroactive period, January 1991 through June 1992. As delineated in the "Qualified Case" definition above, cases are first evaluated to determine whether the are eligible for reimbursement in the first retroactive period. The county is required to evaluate the case for reimbursement in the second retroactive period only if the case will receive a reimbursement during the first retroactive period.

This ACWDL provides for reimbursement of cases which were not reimbursed under the previous Sawyer policy letter, ACWDL 95-63. As previously discussed, the only qualified cases not reimbursed under ACWDL 95-63 are cases which could not have been previously identified under the former Sawyer ACWDL, either because the cases were discontinued previous to the month of May 1994, in which counties began flagging cases with TWC or, although continuing cases through this month, were not flagged because they only received TWC in months previous to May 1994. Any continuing qualified cases receiving TWC in May 1994 or a later month will have been previously reimbursed. However, if in the course of determining eligibility for reimbursement under this ACWDL, the county becomes aware that a case is eligible for reimbursement for month(s) later than the April 1994 cut-off, and was not previously reimbursed, the case must be reimbursed for those months under this ACWDL.

Reimbursable Case: A qualified case certified as having met its pre-Sawyer SOC for which an applicable earned income deduction(s) results in a decreased SOC (the post-Sawyer SOC).

Discontinued Case: A case which was discontinued before May 1994.

Qualifying Individual: The person in a qualified case who received the qualifying TWC.

Case Conversion And Calculation of Post-Sawyer SOC: Case conversion means recalculating the qualified case's SOC to reflect that the case's qualifying TWC payment(s) is earned income by applying the Medi-Cal $90 Work Expense Deduction (Title 22, California Code of Regulations (CCR), Section 50553.1) to the case's qualifying TWC payments. The recalculated SOC is the case's Post-Sawyer SOC.

Applicant: Former or current beneficiaries who, after responding to the Sawyer Poster Notice, submit a properly completed Sawyer Reimbursement Application form (Exhibit A) to the appropriate county welfare office.

SECTION IV. SAWYER POSTER NOTICES AND OTHER PUBLIC NOTICES

Posting Notices At CWDs: Pursuant to the settlement agreement, beginning August 1, 1996 through October 31, 1996, counties must display Sawyer Poster Notices (Exhibit B) in visible locations at their county welfare department (CWD) locations serving Medi-Cal applicants and beneficiaries. The purpose of these posters is to provide notice regarding the availability of Sawyer reimbursement benefits to persons in cases which were discontinued previous to May 1994 and which were therefore not flagged under the instructions provided in ACWDL 94-49, nor identifiable through the Quarterly Status Report process described in that ACWDL. The posters will advise persons that if they met certain requirements during the Sawyer Reimbursement period they may contact their county welfare office for a Sawyer Reimbursement Application. Counties will issue the Sawyer Reimbursement Application to persons who request one on or before October 31, 1996.

Duplication of Poster Notice And Reimbursement Application: This ACWDL transmits "camera-ready" originals of the Sawyer Poster Notice (Exhibit B) and the Sawyer Reimbursement Application (Exhibit C). Counties will use the originals provided in these two Exhibits to make copies. The Poster Notice is on 11" by 17" paper. Exhibit B contains this notice on a 11" by 17" sheet, and on two 8 ½" by 11" sheets. The latter configuration may facilitate the duplication process in those counties which are not able to easily duplicate an 11" by 17" sheet. The Sawyer Reimbursement Application is on an 8 ½" by 11" sheet and should pose no duplication problems. DHS expects that counties will not need to duplicate great numbers of these applications.

Other Public Notices: Pursuant to the settlement agreement, are requested to have the Sawyer Poster Notice posted at food stamp outlets visited by the public. Please follow the duplication instructions provided in the sub-heading above. Pursuant to the settlement agreement, DHS also will request the State Compensation Insurance Offices to display these posters at their public offices.

SECTION V. , SAWYER APPLICATIONS AND IDENTIFICATION OF CASES FOR REIMBURSEMENT

Beginning August 1, 1996 counties may expect to receive requests for Sawyer Reimbursement Application forms from persons responding to posted Sawyer Notices. For properly completed

application forms received by the county no later than October 30, 1996, the county must review case files and any other pertinent records to determine whether the Application corresponds to a qualified case within the Sawyer Reimbursement Period (see definition) which was not previously identified and reimbursed pursuant to ACWDL 95-63. Sawyer Applications received after October 31, 1996 are not eligible for reimbursement and counties need not review case files for these late claims.

SECTION VI. CONVERTING THE CASE BUDGET FOR QUALIFIED CASES; ADJUSTING SOC

Converting The Continuing Case Budget And Adjusting SOC: Beginning August 1, 1996, after (I) receiving a timely properly completed Sawyer Application for a Medi-Cal case, (ii) determining that the case was not previously reimbursed under Phase I of Sawyer (ACWDL 95-63), (iii) identifying the months within the Sawyer Reimbursement Period, if any, in which the case is a qualified case (see definition of qualified case in Section III), (iv) and obtaining the necessary verification (see Section IX), the county will recalculate and adjust the case's SOC for those months in which the case met its pre-Sawyer SOC by applying the $90 Work Expense deduction to the person's qualifying TWC, to the extent this deduction has not already applied to the person's other earned income.

As discussed in the "Qualified Case" definition in Section III, the Sawyer Reimbursement Period consists of two sub-periods. A case need not be evaluated for reimbursement for the January 1991 through June 1992 period unless it will receive a reimbursement in the July 1992 through April 1994 period.

In the event the county requests verification from the applicant, he/she has 30 days to provide such verification. In addition, beneficiaries have another 15 days to provide this verification if there is good cause for the beneficiary being unable to provide the verification within 30 days. The items requiring verification are discussed in Section IX. Once the county has fulfilled its obligations to obtain verification, and 45 days have elapsed since the county has requested verification from the applicant, the county must commence recalculation of the case's SOC with the verification the county has in its possession.

SECTION VII. DETERMINING THE REIMBURSEMENT FOR QUALIFYING CASES

Calculating The Reimbursement: After the case budget has been converted (see Section VI) for those months in the Sawyer Reimbursement Period in which the case is a qualified case, counties

will determine the monthly reimbursement. The monthly reimbursable amount will be equal to the amount by which the case's pre-Sawyer SOC for the month exceeds the case's post-Sawyer SOC for the month. Because this amount will be equal to the portion of the $90 deduction which is applicable to that month's qualifying TWC, counties may wish to use the shortcut of deriving the monthly reimbursable amount as that portion of the $90 deduction applicable to the month's qualifying TWC. The total reimbursable amount for the case is equal to the sum of the monthly reimbursable amounts. Counties will enter the total reimbursement amount on the "Sawyer Reimbursement Request" form (see Exhibit A), and then send this completed form to DHS. This Reimbursement Request form is discussed below.

SECTION VIII. COMPLETING AND TRANSMITTING THE SAWYER REIMBURSEMENT REQUESTS

The "Sawyer Reimbursement Request" (Exhibit A) is the vehicle which DHS will use to issue Sawyer reimbursement checks. Counties will complete and transmit to DHS a "Sawyer Reimbursement Request" form for each case which the county determines will receive a Sawyer reimbursement. For cases which the county determines will receive a reimbursement, counties must transmit the completed Reimbursement Requests to DHS within 30 days of calculating the reimbursement for the case. DHS will use this information to issue Sawyer reimbursement checks.

Mail the Sawyer Reimbursement Requests to:

Department of Health Services
Medi-Cal Eligibility Branch
Attn: Sawyer Reimbursement, Phase 2
714 P Street, Room 1719
Sacramento, CA 95814

SECTION IX. VERIFICATION

Verification of TWC: Before converting the case budget or adjusting SOC under the Sawyer remedies, counties must verify (1) that the payments in question are qualifying TWC payments, and (2) the months in which such payments were received. Issuance of a TWC award letter from the insurance company or other entity making the TWC payment, which letter will identify that the payment is a temporary disability indemnity payment (temporary disability indemnity payment is the term-of-art used to denote a TWC payment), the amount of the payment due, and the duration and schedule of payments, is required by workers compensation law.

An outline of a TWC award letter is included in Exhibit D. Section 9812(a)(1) of this Exhibit outlines the required content of a TWC award letter. Other sections in this Exhibit provide background to counties regarding other kinds of Workers Compensation notices. A TWC award letter provides sufficient verification of the TWC payment amount and of the date the TWC payments began. A TWC check or check stub for a month is sufficient verification that TWC payment was received in that month if the check or check stub clearly states that the payment is a TWC payment. The check or check stub is not verification that TWC was received in previous months. Notations in the case record establishing the months and amounts in which TWC was received are sufficient verification of the months in which TWC was received. In the absence of verification that a payment received in a month is a TWC payment, and the amount of that payment, the case is not eligible for Sawyer benefits in that month.

The first TWC payment may contain a lump sum component to cover the period between the TWC recipient's application for worker's compensation and the determination of the recipient's eligibility for TWC. A TWC award letter should separately identify this retroactive TWC component by amount and indicate the retroactive period it is intended to cover. The portion of the total TWC payment paid in a month that is attributable to the lump sum payment is not income because it is considered to be property pursuant to Title 22, CCR, Section 50455. Ongoing TWC payments are paid bimonthly.

TWC is paid for temporary partial or total disability arising from a work-related injury. The TWC recipient's injury is considered temporary while the treating physician believes his/her condition may improve. At the point where the disability is classified as "permanent and stationary," TWC payments should terminate and permanent disability payments begin. Permanent disability payments continue to be treated as unearned income for Medi-Cal purposes.

Customarily, permanent disability payments are also frequently paid bimonthly. Permanent disability payment amounts paid bimonthly are usually considerably less than the TWC payments. While the TWC recipient must report when his/her TWC payments change to permanent worker's compensation payments, a reduction in income for a case in which TWC is being received should alert counties to a possible transition of TWC payments to permanent disability payments. Counties may require beneficiaries to corroborate TWC at any time by submitting a check stub from the TWC payor which matches the TWC award letter amount.

Applicable Earned Income Deduction Verification: The $90 Work Expense Deduction (Title 22, CCR, Section 50553.1) is always applicable to TWC, to the extent it has not been applied to other earned income of the TWC recipient. The other earned income deductions are not applicable for purposes of determining the Sawyer Reimbursement under this ACWDL.

Medical Expense Verification: Because under this ACWDL, only cases which have met their pre-Sawyer SOC can be qualified cases, the amount of the case's medical expenses will be equal to the case's SOC. Therefore, verification of the case's medical expenses consists of verifying that the case was certified as having met its SOC. Verification that the case was certified as having met its SOC may be accomplished as follows:

1. For counties in which the Benefits Identification Card (BIC) has replaced the paper card (called BIC counties), medical expenses incurred by a case will be verified by inspecting the Medi-Cal Eligibility Data System (MEDS) screens. The MEDS screen will show whether the SOC has been met for the month.

2. For all counties, for months in which the MC 177 "Record of Health Care Costs" was in use, this form may be used to ascertain whether the case met is SOC for the month.

3. For all counties, for months previous to the 15 month limit applicable to the MEDS or SOCR screens, continuing back through January 1, 1991, the Data Systems Branch of DHS will provide SOC-verification reports for cases for which counties have requested this information (see ACWDL 96-16). For each month within the Reimbursement Period for which the county has requested SOC-verification for a case, the report will show whether the case was certified as having met its SOC. These reports will be the only means for ascertaining whether a case's SOC was met during the "GAP" months: those months subsequent to the period covered by the MC-177 but prior to the 15 months covered by MEDS. Counties may also use this option in place of inspecting MC-177s even for the period for which the county has MC-177s.

SECTION X. MEDI-CAL EXPENSES FROM SAWYER-REIMBURSED CASES NOT APPLICABLE TO SOC UNDER HUNT

A medical expense may not be applied both toward SOC in the month of eligibility and in a later month under Hunt v. Kizer. It follows that once medical expenses are counted in determining a Sawyer reimbursement such expenses may not be applied toward SOC in any later month under the Hunt v. Kizer old medical bill remedy. Such bills either have already been reimbursed under the Sawyer remedy or were used to certify SOC for purposes of providing such reimbursement. Similarly, if medical expenses incurred in the month of eligibility have already been applied toward SOC in a later month under Hunt v. Kizer, they cannot be re-applied in any other month for purposes of obtaining a Sawyer reimbursement.

SECTION XI. IDENTIFICATION OF THE SAWYER REIMBURSEMENT RECIPIENT

The Sawyer reimbursee is the applicant provided he/she was an eligible or ineligible member of the MFBU of a qualified case during the Sawyer reimbursement period whose income was counted for purposes of determining the MFBU's SOC. The reimbursee's address will be that stated on the claim form. When completing the "Sawyer Reimbursement Request," counties will include the name and address of the reimbursee. DHS will issue the Sawyer reimbursement in the name of the reimbursee to the reported address. Occasionally DHS may issue the reimbursement to another person in the MFBU, if appropriate. DHS reimbursement to any person in the case MFBU fulfills DHS' liability for Sawyer reimbursement for the case.

SECTION XII. MAINTAINING RECORDS OF CASES WHICH QUALIFIED FOR SAWYER REIMBURSEMENT

For the purpose of settling potential disputes regarding Sawyer benefits, counties must maintain records of the calculations used to determine the post-Sawyer SOC and reimbursement amount for all cases which were evaluated for a Sawyer reimbursement. Counties must keep copies of all Sawyer-related documents issued to, or received from, the beneficiary. Counties must keep Sawyer-related documents received from any source used for verification purposes. Counties must also compile and maintain a log of cases which will receive a Sawyer Reimbursement. A sample log form is provided in Exhibit E. The retention period for the documentation described in this paragraph is one year.

SECTION XIII. PROVISION OF NOTICE OF ACTION REGARDING APPROVAL/DENIAL

Counties will issue Sawyer NOA's (enclosed as Exhibit F) to all persons submitting a Sawyer Reimbursement Application. For Applications for which the county has determined that there is either no Medi-Cal case, or no qualified Medi-Cal case, the "denial" NOA will be issued within 30 days of the county's making that determination. For Applications for which the county has determined that there is qualified case, the appropriate NOA, a "denial," or an "approval," will be issued within 30 days of the county's making the determination whether the qualified case will receive a reimbursement. The Sawyer NOA2.1 will be issued to cases which will not receive any reimbursement. The Sawyer NOA2.2 will be issued to cases which will receive a reimbursement. These NOAs will not be available on SAWS. This ACWDL does not alter the standard NOA notification issued to new cases.

Counties may make copies of these NOAs for manual distribution from the "camera-ready" originals provided in Exhibit F , or counties may use these originals as templates for the issuance of county-automated NOAs.

SECTION XIV. STATISTICAL REPORTING

By February 15, 1997, counties will submit the following statistical information to DHS on the form provided in Exhibit G: (1) a tally of the number of cases which qualified for a retroactive reimbursement under this ACWDL for any months beginning January 1991 through December 31, 1995, and (2) a tally of the total number of months which these cases qualified for retroactive reimbursement under this ACWDL for the period January 1991 through December 31, 1995. Counties will send these tallies to:

Department of Health Services
Medi-Cal Eligibility Branch
Attn: Sawyer Statistics
P.O. Box 942732
Sacramento, CA 94234-7320

If you have questions regarding the subject matter of this ACWDL, please contact Dave Rappolee of my staff at (916) 657-0163.

Sincerely,

ORIGINAL SIGNED BY
GLENDA ARELLANO for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

EXHIBIT A

DHS Address: Attn: Sawyer Reimbursement, Phase 2
Dept. of Health Services
M.E.B. Clerical Unit, Rm 1719
714 P Street
Sacramento, CA 95814

Issuing County (Address)

SAWYER REIMBURSEMENT REQUEST, PHASE 2

To: Carol O'Bryant
DHS Accounting
8/1080

From: Medi-Cal Eligibility Branch
8/1650

This is to advise you that the following individual qualifies for a reimbursement under the settlement agreement for the Sawyer v. Anderson, Belshe , et al. litigation, U.S. District Court, Eastern District of California, case #CIV S-94-0228 GEB JFM. Please prepare and issue a reimbursement check for the amount shown below to the address provided.

TO BE COMPLETED BY THE COUNTY - PLEASE PRINT

Reimbursee Name: _____ SSN_____
(MFBU/Household Head)

Address: _____

_____

_____

TWC Recipient's Name and SSN _____
(Name) (SSN)

Reimbursement Total: _____

Reimbursement Months, From _____ To _____;
Other Reimbursement months _____

Case ID Number _____

Signature of County Preparer: _____ Date: _____

Phone Number: _____ Title: _____

FOR STATE USE ONLY

Certified by: _____ Date: _____
Authorized M.E.B reviewer

Phone Number: _____

EXHIBIT B

INFORMATION ABOUT THE SAWYER POSTER NOTICES

Translations of the English version of the Sawyer Poster Notice were not completed in time to include the complete, multi-language Sawyer Poster Notice in this Exhibit. The complete Notice will be separately transmitted. The enclosed English-only version, showing the final language of this poster, is provided for informational purposes only and is NOT for posting.

The separate transmission will include a single-sheet 11" by 17" version and a two sheet version of this translated Poster to facilitate duplication.

(swposter.not)

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

Display August 1, 1996 through October 31, 1996

WELFARE MAY OWE YOU MONEY

Were you on Medi-Cal from July, 1992 through April, 1994 in a family which had a Medi-Cal share-of-cost and at least one child, or in which someone in the household was pregnant? If so, did you or any person in your Medi-Cal family budget unit receive Temporary Disability Indemnity (TDI) during this time? TDI payments are paid due to an job-related injury or illness. If you can answer yes to these questions, you may be eligible for money because the Medi-Cal program did not treat your TDI as earned income. If you feel that you meet these requirements and wish to be considered for this benefit, obtain a Sawyer Reimbursement Application from the county welfare office. You must complete, and turn-in the Sawyer Reimbursement Application to the county welfare office by October 31, 1996 in order to be considered for the money benefit. If your household is eligible for the money for the period starting July 1, 1992 you may also be eligible for money for the period of January 1, 1991 through June 30, 1992.

EXHIBIT C

SAWYER REIMBURSEMENT APPLICATION

Were you on Medi-Cal from July, 1992 through April, 1994 in a family which had a Medi-Cal share-of-cost and at least one child, or in which someone in the household was pregnant? If so, did you or any person in your Medi-Cal family budget unit receive Temporary Disability Indemnity (TDI) during this time? TDI payments are paid due to an job-related injury or illness. If you can answer yes to these questions, by completing this application you may be found to be eligible for money because the Medi-Cal program did not treat your TDI as earned income. Money you receive as a result of this application will not be counted toward your Medi-Cal share-of-cost. You must complete and turn-in this application your county welfare office by October 31, 1996 to be considered for the money benefit.

For purpose of the application below:

SSN = Social Security Number; DOB = Date Of Birth; TDI = Temporary Workers Compensation

Name _____ SSN _____ Age _____

Phone Number _____ DOB _____

Current Address _____

_____

_____

Name of person who received TDI _____ SSN _____ DOB_____
(If other than yourself)

Indicate the approximate period of
time TDI was received: Beginning month/year _____ Ending month/year _____

Indicate the approximate period of time you
were on Medi-Cal with a SOC: Beginning month/year _____ Ending month/year_____

During this period, did you have children, were you
pregnant, or were you a minor (less than 21) ? Yes ___ No ___

During this period, was the person getting
TDI 65 or older, blind, or disabled? Yes___ No ___

During the period that you were on Medi-Cal and receiving TDI, what county(ies) were you living in:
_____?

I declare under penalty of perjury that I am the applicant who has completed this form and that the information I have provided is true: Signed _____
Date _____

EXHIBIT D

Quick Reference to Notice Contents

Benefit Notice Letters

§9810(c)

- Benefit notice letters may be produced on claims administrators letterhead.

General Benefits Information Pamphlet

§9810(d)

- A general information pamphlet shall be sent with first notice of benefits.

Temporary Disability Indemnity Notices

§9812(a)(1) Notice of First Temporary Disability Indemnity Payment -- Required elements:

- Amount of TD indemnity due
- How it was calculated
- Duration and schedule of payments
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: No later than the 14th day after the employer's date of knowledge of injury and disability.

§9812(a)(2) Notice of Delay in Any Temporary Disability Indemnity Payment– Required elements:

- That there will be a delay
- The reasons for it
- The need, if there is one, for additional information required to make a determination
- When a determination is likely to be made
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: Within 14 days of the date of knowledge of injury and disability.

Additional Notice(s) of Delay in Any TD Indemnity Payment--Required elements:

- That there will be a further delay
- The reasons for it
- The need, if any, for additional information required to make a determination
- When a determination is likely to be made
- The employee's remedies

When to send: Within 5 days after the determination date specified in the prior delay notice.

§9812(a)(3) Notice of Denial of Any Temporary Disability Indemnity Payment--Required elements:

- That liability for a period of claimed TD has been denied
- Reasons for it
- The employee's remedies

When to send: Within 14 days after the determination to deny is made.

Notices of Resumption, Change, and Ending of Benefits

§9812(b) Notice of Resumed Benefit Payments (TD, SC, PD, VRTD/VRMA)--Required elements:

- Amount of indemnity due
- Duration and schedule of payments
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: Within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

§9812(c) Notice of Changed Benefit Rate or Schedule (TD, SC, PD, VRTD/VRMA)--Required elements:

- Amount of the new benefit rate or description of new benefit payment schedule
- Reason why the rate is being changed, if applicable
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: Before or with the new payment.

§9812(d) Notice that Benefits Are Ending (TD, SC, PD, VRTD/VRMA)--Required elements:

- That benefit payments are ending
- Reason for it
- Accounting of all benefits paid in that species of benefit, including dates and amounts paid and any related penalties
- The employee's remedies

When to send: With the last payment of TD, SC, PD, VRTD/VRMA. If the decision to end payments is made after the last payment, within 14 days of the last payment.

Permanent Disability Notices

§9812(e)(1) Injury Before Jan. 1, 1991 and Existence and Extent of Permanent Disability is Known--Required elements:

- Amount of the weekly PD indemnity payment
- How it was calculated
- The duration and frequency of payments
- Total amount to be paid
- The employee's remedies if he or she disagrees

When to send: Within 14 days after the claims administrator knows that the injury has caused permanent disability and its extent.

§9812(e)(2) Injury Before Jan. 1, 1991 and Existence of Permanent Disability is Known, Extent is Uncertain--Required elements:

- Amount of the weekly PD indemnity payment
- How it was calculated
- The duration and schedule of payments
- Reasonable estimate of the amount of PD indemnity to be paid
- That the employee's medical condition will be monitored until the extent of PD can be determined and that PD payments will be revised then, if appropriate
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: Within 14 days after the last payment of TD indemnity or, if there was no compensable TD, within 14 days after knowledge that the employee's injury has resulted in PD.

§9812(e)(3) Injury Before Jan. 1, 1991 and Existence of Permanent Disability is Uncertain--Required elements:

- That the claims administrator cannot yet determine whether the injury will cause PD
- Reasons for the delay in this determination
- The need, if any, for additional information required to make a determination
- When a determination is likely to be made
- If the reason for the delay is that the employee's medical condition is not permanent and stationary, that the employee's medical condition will be monitored until it is P&S, at which time an evaluation will be performed to determine the amount of PD indemnity, if any, that is due
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: Within 14 days after the last payment of TD indemnity or, if the claims administrator paid no TD indemnity, within 14 days of receiving a claim or medical report alleging the existence of PD.

§9812(e)(4) Injury Before Jan. 1, 1991--Notice That No Permanent Disability Exists--Required elements:

- That the injury has caused no PD
- The employee's remedies

When to send: Within 14 days after the claims administrator makes the determination.

§9812(f)(1) Injury in 1991-1993, Condition Not Permanent and Stationary, May Cause PD, Monitoring Until P&S Date--Required elements:

- That PD is or may be payable but the amount cannot be determined
- That the employee's condition will be monitored until P&S, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment and need for continuing medical care
- Estimated date when this determination is likely to be made
- The employee's remedies

When to send: Together with the last payment of TD indemnity

Injury in 1991-1993, Condition Still Not Permanent and Stationary, Additional Notice(s)--Required elements:

- That there will be a further delay in determining existence and extent of PD
- Same as required for original such notice

When to send: Within 5 days after the determination date last specified.

§9812(f)(2) Injury in 1991-1993, Condition Becomes P&S, May Cause Permanent Disability--Notice of QME Procedures--Required elements:

- That the employee's condition is permanent and stationary
- Procedures for evaluating PD and need for continuing medical care
- The employee's remedies

When to send: Within 5 working days after receiving information indicating that the employee's condition is P&S and has caused or may have caused permanent disability.

§9812(f)(3) Injury in 1991-1993, Notice of Permanent Disability Advances--Required elements:

- That the employee will receive a weekly PD indemnity payment
- How it was calculated
- The duration and schedule of payments
- The claims administrator's reasonable estimate of PD indemnity to be paid
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

When to send: When the claims administrator knows that the employee has sustained permanent disability: within 14 days after the last payment of TD indemnity, or within 14 days after knowledge that the injury has resulted in PD, whichever is later.

§9812(f)(4) Injury in 1991-1993, Notice That No Permanent Disability Exists--Required elements:

- That no PD indemnity is payable
- Process to obtain a formal medical evaluation to contest the determination that the employee has no PD
- The employee's remedies

When to send: Within 14 days after the claims administrator determines that the injury has caused no PD.

§9812(g)(1) Injury on or after Jan. 1, 1994, Condition Not Permanent and Stationary, May Cause PD--Notice of Monitoring Until P&S Date--Required elements:

- That PD indemnity is or may be payable but the amount cannot yet be determined
- That the employee's condition will be monitored until it is P&S, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment and need for continuing medical care

- Estimated date when a PD determination is likely to be made
- Mandatory language of §9812(g) which the claims administrator may preface with the statement:
  "Even though you're represented by an attorney, State Law requires us to advise you of the following."

When to send: With the last payment of TD indemnity, if the injury may result in PD but the employee's condition is not P&S.

Condition Still Not P&S--Additional Notice(s)--Required elements:

- That there will be a further delay in the PD determination
- All other elements included in the original notice
- The employee's available remedies

When to send: No later than 5 days after the determination date last specified.

§9812(g)(2)(A), (B), and (C) Injury on or after Jan. 1, 1994, Condition P&S, Causes PD, Notice of QME Procedures to Unrepresented Employee--
Required elements:

- The claims administrator's determination of the amount of PD indemnity payable
- Basis for the claims administrator's determination of that amount
- Whether there is need for continuing medical care
- Statement that if either party disagrees with the treating physician's report, the employee must request a comprehensive medical evaluation from a QME panel
- Indication of whether or not the claims accepts the treating physician's evaluation of PD
- QME panel request form
- Statement that the employee may contact an Information and Assistance Officer to have the treating physician's evaluation rated by the Disability Evaluation Unit, if the claims administrator is not requesting a rating from the DEU
- Statement that the employee will be receiving a DEU rating on the treating physician's evaluation, if the claims administrator *is* requesting such a rating
- Mandatory language of §9812(g)
- The employee's other available remedies

When to send: Together with the last payment of TD indemnity or within 14 days of determining the amount of PD indemnity payable.

§9812(g)(2)(D) Injury on or after Jan. 1, 1994, Condition P&S, Causes PD, Notice of QME Procedures to Represented Employee--Required elements:

- The claims administrator's determination of the amount of PD indemnity payable
- Basis for the claims administrator's determination of that amount
- Whether there is need for continuing medical care
- That the employee may obtain an additional medical evaluation by an Agreed Medical Examiner
- That if no agreement can be reached on an AME, he or she may obtain an evaluation by a Qualified Medical Evaluator of the employee's choice, and that the arrangements for such an evaluation should be discussed with his or her attorney
- Indication of whether or not the claims administrator disputes the treating physician's evaluation of the employee's permanent disability
- Mandatory language of §9812(g), which the claims administrator may wish to preface with the statement:

  "Even though you're represented by an attorney, State law requires us to advise you of the following."
- The employee's other available remedies

When to send: Together with the last payment of TD indemnity or within 14 days of determining the amount of PD indemnity payable.

§9812(g)(3)(A), (B), and (C) Injury on or after Jan. 1, 1994, Notice to Unrepresented Employee That No Permanent Disability Exists–Required elements:

- That no PD indemnity is payable
- That if the employee disagrees with the treating physician's report on which the claims administrator made its determination, he or she may request a comprehensive medical evaluation by a QME panel physician
- Advice regarding the procedure for requesting a QME panel
- QME panel request form
- That the employee may contact an Information and Assistance Officer to have the treating physician's report rated by the Disability Evaluation Unit
- That the employee will be receiving a DEU rating on the treating physician's report, if the claims administrator has requested such a rating
- Mandatory language of §9812(g)
- The employee's other available remedies

When to send: Together with the last payment of TD indemnity or within 14 days after the claims administrator determines that there is no permanent disability.

§9812(g)(3)(D) Injury on or after Jan. 1, 1994, Notice to Represented Employee That No Permanent Disability Exists--Required elements:

- That no PD indemnity is payable
- That an additional evaluation may be obtained from an Agreed Medical Evaluator
- That if no agreement can be reached on an AME, the employee may obtain an additional evaluation by a Qualified Medical Evaluator of his or her choice, and that arrangements for such an evaluation should be discussed with the employee's attorney
- Indication of whether or not the claims administrator disputes the treating physician's evaluation of the employee's permanent impairment
- Mandatory language of §9812(g), which the claims administrator may preface with the statement:
  "Even though you're represented by an attorney, State law requires us to advise you of the following."
- The employee's other available remedies

When to send: Together with the last payment of TD indemnity or within 14 days after the claims administrator determines that there is no permanent disability.

§9812(g)(4) Injury on or after Jan. 1, 1994, Notice of PD Indemnity Advances--Required elements:

- That the employee will receive a weekly PD indemnity payment
- How it was calculated
- Duration and schedule of payments
- The claims administrator's reasonable estimate of PD indemnity to be paid
- Mandatory language of §9812(g) which the claims administrator may preface with the statement:
  "Even though you're represented by an attorney, State law requires us to advise you of the following."

When to send: Within 14 days after the last payment of TD indemnity, or within 14 days after knowledge that the injury has resulted in PD, whichever is later.

Notices in Death Cases

§9812(h)(1) Notice of Benefit Payment Schedule to Dependents in Death Case--Required elements:

- Amount of the death benefit payable
- How it was calculated
- Duration and schedule of payments
- That additional information may be obtained from an Information and Assistance Officer of the Division of Workers' Compensation

EXHIBIT E

(SWREIMBR.LOG) (This form is a suggested form for county use. It can be used to prevent double reimbursements by searching on a unique identifier, such as case I.D. #. To search in Wordperfect, select "Edit," then "Find.")

SAWYER REIMBURSEMENT LOG (SAMPLE)

County Address and Identification Number

Medi-Cal Case Last Name, first name, Case I.D. Number	Reimbursee Name & SSN	Reimbursee Address	Sawyer Reimbursement Total	Period To Which Reimbursement Applies

EXHIBIT F

PLEASE READ BEFORE USING THESE NOTICES OF ACTIONS

The English language NOAs in this Exhibit are ready for use. DHS was unable to translate these NOAs into Spanish in time to include it with this ACWDL. DHS will transmit the Spanish language versions via a separate All County Information Letter as soon as they become available. DHS apologizes for the inconvenience.

NOTICE OF ACTION

County of:

County name and address:

Notice Date:
Case Name:
Case Number:
Worker Name:
Telephone:
Address:

Addressee:

You do not qualify for a reimbursement under Sawyer. This is because:

- ☐ 1. No Medi-Cal case could be identified from your application.
- ☐ 2. No AFDC MN or MI person in your case received Temporary Workers Compensation (TWC) during the July 1992 through April 1994 Reimbursement Period.
- ☐ 3. Your case has already received a Sawyer Reimbursement.
- ☐ 4. Your case did not meet its share of cost (SOC) in any month in which your case received TWC.
- ☐ 5. The $90 deduction was fully applied to your other earned income and you qualified for no other AFDC MN/MI deduction.
- ☐ 6. Your application was submitted after the October 31, 1996 due date.
- ☐ 7. Other; explanation:

____
____
____
____
____

Rules: These rules apply; you may review them at your welfare office: 50781, 50782, 50783.

Questions? Ask your worker.

If you do not understand English, ask your worker.

បើសិនជាមិនយល់នូវភាសាអង់គ្លេស សូមទាក់ទងនៅអ្នក

ຖ້າຫາກ ທ່ານບໍ່ເຂົ້າໃຈພາສາອັງກິດ, ເຊີນທ່ານຖາມ ເວີເກີ ຂອງທ່ານ.

如你不懂英語，請問你的資格審查員 (WORKER)

Si no entiende el inglés, hable con su trabajador(a)

Nếu quý vị không hiểu tiếng Anh, xin hỏi nhân viên xã-hội

State Hearing: If you think this action is wrong, you can as for a hearing. The back of this page tells how.

NOTICE OF ACTION

County of:

County name and address:

Notice Date:
Case Name:
Case Number:
Worker Name:
Telephone:
Address:

Addressee:

The county has determined that your share of cost (SOC) has decreased as a result of the fact that Medi-Cal now counts your case's temporary workers compensation (TWC) as earned income.

Your SOC has been changed to $_____ from $_____ for _____.

Your new SOC was determined as follows:

Gross income:	$_____
Net nonexempt income:	$_____
Maintenance need:	$_____
Excess income:	$_____
Share of cost:	$_____

Your will receive a reimbursement of $ _____

Questions? Ask your worker.

If you do not understand English, ask your worker.

បើសិនជាមិនយល់ភាសាអង់គ្លេស សូមទាក់ទងវត្ថិអ្នក

ຖ້າຫາກ ຕ່ານບໍ່ເຂົ້າໃຈພາສາອັງກິດ, ຊຶ່ນຕ່ານຖາມ ເວີ້ເກີ ຂອງຕ່ານ.

如你不懂英語，請問你的資格審查員 (WORKER)

Si no entiende el inglés, hable con su trabajador(a)

Nếu quí vị không hiểu tiếng Anh, xin hỏi nhân viên xã-hội

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

Rules: These rules apply; you may review them at your welfare office: 50653.5(B), 50781, 50782, 50783.

EXHIBIT G

(swstats.rep)

SAWYER, STATISTICS REPORTING FORM --PHASE 2

By March 15, 1997 please submit this form, summarizing the statistics for all converted cases, to the Department of Health Services at the following address:

Dave Rappolee
Department of Health Services
Medi-Cal Eligibility Branch
714 P Str., Room 1650
P.O. Box 942732
Sacramento, California 95814

County Name _____

1. Number of cases which qualified for a reimbursement under Sawyer, Phase 2: _____.

2. The total number of months for which persons qualified for reimbursement under Sawyer, Phase 2: _____.

Name of Person Completing Form (Print/Typed) _____

Signature of Person Completing Form _____

Date _____ Phone Number _____

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

June 24, 1996

Letter No.: 96-33

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (MC 219)
IMPORTANT INFORMATION ABOUT RESIDENCY (MC 214)

The purpose of this letter is to transmit a sample copy of the newly revised and reformatted MC 219. As of September 1, 1996, the 5/96 version of the MC 219 obsoletes all previously issued versions of the following Rights and Responsibilities forms:

- MC 216: Rights of Persons Requesting Medi-Cal;
- MC 217: Medi-Cal Responsibility Checklist;
- MC 218: Privacy and Confidentiality Notification; and
- MC 219 (11/93): Important Information For Persons Requesting Medi-Cal.

All pertinent information on the MC 216, MC 217, and the MC 218 was incorporated into the 11/93 version of the MC 219 when it was released as a single informing notice. The 5/96 revisions to the MC 219 include:

- Informing language which reflects the Department's implementation of the Appellate Court ruling in the Crespin case;
- Technical changes in the discussion of third party liability, recovery, other health insurance coverage information, and Managed Care health plan options;
- Overall simplified wording;
- An interpreter signature and telephone number line; and
- ~~Removal of pages 5~~ ("Important Information About Residency") and 6 ("Citizenship/Immigration Status Information For Applicants and Beneficiaries of Medi-Cal") which were previously included in the 11/93 version.

Pages removed from the MC 219 (11/93)

Due to the infrequent use of the "Important Information About Residency" page and escalating printing costs, the Medi-Cal Eligibility Branch (MEB), after consulting with the Medi-Cal Forms Committee, made the decision to detach the "Important Information About Residency" page from the new MC 219. The "Important Information About Residency" page is now a separate form and is numbered as the MC 214. The MC 214 must be completed by the applicant/beneficiary whenever evidence of residency is required and the applicant/beneficiary does not have one of the items listed on that form. Persons who sign the MC 214 are still required to provide some evidence of California residency in accordance with established policies for verification of residency. A sample copy of the new MC 214 is enclosed for your information. The MC 214 is available through the Department of Health Services' warehouse beginning August 1, 1996.

Information in the "Citizenship/Immigration Status Information For Applicants and Beneficiaries of Medi-Cal" page of the previous version of the MC 219 has been updated to reflect the State Appellate Court ruling in the Crespin case and incorporated into the May 1996 version of the MC 13. The revised MC 13 and a description of the requirements for implementing the Appellate Court decision have been sent to the counties in a separate All County Welfare Directors Letter.

Completing the MC 219 (5/96)

County staff are reminded that the MC 219 must be reviewed with the applicant/beneficiary or his/her representative. SAWS/ISAWS counties must manually issue the MC 219 because the SAWS generated SAWS 2A currently does not contain adequate information for Medi-Cal only cases. County staff is to file the original signature page in the case record and give the complete informing notice to the applicant/beneficiary or his/her representative.

Counties are instructed to begin using the new MC 214 and the revised MC 219 on September 1, 1996, and to discard all previous versions of these forms on that date. A three-month supply of the revised MC 219 forms will be shipped to counties by August 1, 1996. Questions regarding the MC 214 or residency may be directed to John Zapata at (916) 657-0725 and questions regarding the MC 219 may be directed to Alice Mak at (916) 654-0573.

Sincerely,

Frank S. Martucci

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

Enclosure 1-A

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine the Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

5-29-96

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

5-29-96

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. ~~I will have the right~~ to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

5-29-96

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA reverses the denial decision and approves my SSA disability claim, my Medi-Cal will not stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I, _____, am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date
Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date

"IMPORTANT INFORMATION ABOUT RESIDENCY"

Medi-Cal applicants who have one of the items listed below **MUST** provide it as evidence of residency. Medi-Cal applicants who **DO NOT** have one of the items listed below must sign this page **AND** provide other evidence of residency. ***DO NOT SIGN THIS PAGE IF YOU HAVE ONE OF THE ITEMS LISTED BELOW.***

I UNDERSTAND that the welfare department will only consider evidence other than the items listed below if I do not have one of the following items:

- A recent California rent or mortgage receipt or utility bill in my name.
- A current and valid California Motor Vehicle Driver's License or California Identification Card issued by the California Department of Motor Vehicles.
- A current and valid California motor vehicle registration in my name.
- A document showing that I am employed in this State.
- A document showing that I have registered with a public or private employment service in this State.
- Evidence that I have enrolled myself or my children in a school in this State.
- Evidence that I am receiving public assistance other than Medi-Cal in this State.
- Evidence that I have registered to vote in this State.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I DO NOT POSSESS ANY OF THE ITEMS LISTED ABOVE.

Applicant Signature	Date
Person Acting for Applicant (Signature)	Date

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY
PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

June 27, 1995

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 96-34

INSTRUCTIONS FOR SEPTEMBER 1, 1996 IMPLEMENTATION OF THE STATE APPELLATE COURT RULING IN THE CASE OF CRESPIN V. COYE

Ref: Electronic Mail Message Nos. 94120 and 94176

This All County Welfare Directors Letter (ACWDL) transmits instructions for the September 1, 1996 implementation of the citizenship/immigration status declaration and Social Security number (SSN) requirements of Welfare and Institutions Code Section 14011.2 as authorized by the State Court of Appeal ruling in the case of Crespin v. Coye ((1994) 27 Cal.App.4th 700). In addition to describing the implementation requirements authorized by the Court of Appeal decision, this letter includes a summary of the most significant form revisions that were necessary to implement that ruling.

IMPLEMENTATION REQUIREMENTS

Effective September 1, 1996:

- Every person requesting Medi-Cal is required to provide information about his or her citizenship/immigration status by completing the MC 13.

- Every person requesting Medi-Cal who has a SSN at the time of application is asked to provide it regardless of immigration status. However, aliens eligible only for restricted Medi-Cal benefits are not required to provide a SSN as a condition of eligibility (this includes all aliens who claim on the MC 13 that they are not in a satisfactory immigration status)[1].

- Medi-Cal applicants may no longer request full or restricted Medi-Cal benefits. County welfare departments will determine the level of benefits an applicant is potentially eligible for based on citizenship/immigration status information.

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[1]Aliens in a Satisfactory Immigration Status include amnesty aliens with a valid and current I-688, lawful permanent resident aliens, and aliens who are Permanently Residing in the United States Under Color of Law (PRUCOL).

CITIZENSHIP/IMMIGRATION STATUS DECLARATION REQUIREMENTS

Every Medi-Cal applicant is required to provide a written declaration of his or her citizenship or immigration status. This requirement is described in Section "A" of the MC 13 as follows:

> "**Citizenship/immigration status information:** Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential."

To meet this requirement, all Medi-Cal applicants (including all Medi-Cal applicants in Statewide Automated Welfare System (SAWS) counties) are required to complete a MC 13.[2] A copy of the revised MC 13 (dated 5/96) is enclosed with this letter for your information. The revised MC 13 provides applicants with step-by-step instructions for meeting the citizenship/immigration status declaration requirement. The MC 13 includes specific questions which allow United States (U.S.) citizens, U.S. nationals, and aliens who are in a satisfactory immigration status to state their specific status. Aliens who are not in any of these categories must answer "NO" to **each** of these questions in order for the MC 13 to be complete. In addition, aliens who claim to be PRUCOL, **must** indicate which PRUCOL category applies to them in order for the MC 13 to be complete. Detailed instructions regarding proper completion of the MC 13 are included in procedure Section 7G. The procedure manual letter transmitting the new MC 13 procedures was forwarded to the counties concurrent with this letter.

SOCIAL SECURITY NUMBER REQUIREMENT

Effective September 1, 1996, every Medi-Cal applicant who has a SSN is requested to provide it to the county. Current policies requiring U.S. citizens, U.S. nationals, and aliens who claim to be in a satisfactory immigration status to provide or apply for a SSN are not changed by the Crespin ruling.[3] However, administration of the SSN requirement for aliens who are not in a satisfactory immigration status does change.

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[2]Medi-Cal Only applicants in SAWS counties are required to complete and sign an MC 13 manually. Medi-Cal Only beneficiaries in SAWS counties who have not completed an MC 13 must do so at their next annual redetermination.

[3]Under current eligibility policies PRUCOL aliens who do not have a SSN at the time of application are not required to obtain a number as a condition of eligibility for full scope Medi-Cal. This policy will remain in effect until further notice from the Medi-Cal Eligibility Branch.

The updated SSN requirement is described in Section "A" of the MC 13 as follows:

"**Social Security number requirement:** Every person requesting Medi-Cal who has a Social Security number must provide it to the county welfare department. U.S. citizens, U.S. nationals and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

Under the Crespin ruling, the Department has authority to ask all aliens to provide a SSN if they have one, but may not deny eligibility for restricted Medi-Cal benefits to otherwise eligible aliens who claim that they are not in a satisfactory immigration status, and who do not have (or provide) a SSN. **In particular, it is important to note that aliens who claim that they are not in a satisfactory immigration status can establish eligibility for restricted Medi-Cal benefits even if they claim to have a SSN but refuse to provide it to the county.** Aliens eligible for restricted scope Medi-Cal who claim to have a SSN, but who refuse to provide it should be granted eligibility if all eligibility requirements are met. However, these applicants should be referred to State Medi-Cal investigators for an investigation if there is reason to believe that they are withholding any information relevant to their Medi-Cal eligibility.

FORM REVISIONS

In order to implement the Court of Appeal ruling in the Crespin case, the Department has revised several Medi-Cal forms including the MC 13 (Enclosure 1), the MC 210 (Enclosure 2), the MC 210 S-C (Enclosure 3), and the MC 219 (Enclosure 4). Copies of the latest revised versions of each of these forms are enclosed for your information. A three-month supply of the English and Spanish versions of the revised MC 13, MC 210, MC 210-SC, and MC 219 will be shipped directly to counties by August 1, 1996. Counties are instructed to begin using the MC 13 (5/96), MC 210 (5/96), MC 210-SC (5/96), and MC 219 (5/96) on September 1, 1996 and to discard all unused copies of the previous versions of these forms on that date.

MC 13 "Statement of Citizenship, Alienage and Immigration Status"

The May 1996 version of the MC 13 includes major revisions and restructuring necessary to implement the Appellate Court ruling in the Crespin case and to clarify the form. The 5/96 MC 13 includes the following major revisions:

- Updated information about the alien status declaration and SSN requirements is included in the first section of the form along with information previously included in the MC 219 "Citizenship/Immigration Status Information Notice for Applicants and Beneficiaries of Medi-Cal" (formerly page 6 of the MC 219). Other information previously located in other sections of the MC 13 is moved to the first section of the form.

- The "Scope of Benefits Requested" section is eliminated. Applicants may no longer request full or restricted Medi-Cal benefits. That determination is made solely by the counties based on the alien status and other eligibility information provided by the applicant.

- The alien status question asking applicants to indicate whether or not they are in the United States on a visa has been eliminated from the MC 13 and added to the State residency questions included in the MC 210 as question 11b.

- The " FOR COUNTY USE ONLY" section of the MC 13 has been updated. The question asking counties to indicate which documents are in the file has been deleted, and the "Action Taken" categories have been expanded for counties to indicate when full Medi-Cal benefits were granted pending the Immigration and Naturalization Service response to the Systematic Alien Verification for Entitlements (SAVE) inquiry. The latest revision also adds a section for the county to indicate which level of benefits the applicant is potentially eligible to receive based on the information provided on the MC 13.

MC 210 "Statement of Facts (Medi-Cal)"

The 5/96 version of the MC 210 removes the shading from the SSN blocks and revises the language in the black bar on page one which previously advised applicants for restricted Medi-Cal that they were not required to provide a SSN. (The black bar has also been removed from around this text.) The text at the top of page one regarding the SSN requirement now states:

> "Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form."

Also, question 11b was added to ask:

> "Are you or any family member in the United States on a visa or a Border Crossing Card?"

In addition to these changes, the MC 210 cover sheet has been updated to remove any reference to the "Important Information About Citizenship/Alien Status" page previously included in the MC 219, and to include information about the property waiver program. The revised MC 210 also has other revisions which are not related to Crespin implementation. These revisions are described in a separate ACWDL.

MC 210 S-C

The MC 210 S-C has been revised to incorporate the same revisions that were made to the MC 210 as described above.

MC 219 "Important Information For Persons Requesting Medi-Cal"

The 5/96 version of the MC 219 includes the following significant revisions relating to Crespin implementation:

- Explains the SSN requirements for U.S. citizens, U.S. nationals, and aliens in accordance with the Court of Appeal ruling in the Crespin case.
- Adds a bullet explaining that all Medi-Cal applicants are required to make a declaration of their immigration status and that immigration status information is confidential.
- Eliminates the "Citizenship/Immigration Status Information Notice for Applicants and Beneficiaries of Medi-Cal" (page 6 of the MC 219 (11/93)) because that information has been updated and included in the MC 13 "Statement of Citizenship, Alienage, and Immigration Status."

Other revisions to the MC 219, which are not related to implementation of the Court of Appeal ruling in the Crespin case are described in a separate ACWDL.

Other Form Revisions

In addition to revising the necessary Medi-Cal program forms, the Department has prepared revisions to some SAWS forms (including the SAWS 1 and the SAWS 2) in conjunction with the Department of Social Services (DSS). The revised SAWS forms will be shipped in accordance with DSS procedures along with a letter summarizing the changes.

If you have any questions about the new requirements described in this letter, or about any of the updated Medi-Cal forms, please call Mr. John Zapata of my staff at (916) 657-0725.

Sincerely,

Frank S. Martucci

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

5-31-96

State of California—Health and Welfare Agency

Department of Health Services

STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS

ENCLOSURE 1

Print Name of Applicant (The applicant is the person who wants Medi-Cal):	Date:
Print Name of Person Acting for Applicant:	Relationship to Applicant:

SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).

Satisfactory immigration status and full Medi-Cal benefits for aliens: Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency.** Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). **The 16 PRUCOL categories are listed in SECTION B, question 6 below.**

Documented aliens not in a satisfactory immigration status (such as aliens with unexpired visas or unexpired parole status) who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Citizenship/immigration status information: Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential.

Alien status documents and verification requirements: Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the S. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they ave applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

Social Security number requirement: Every person requesting Medi-Cal who has a Social Security number must provide it to the county welfare department. U.S. citizens, U.S. nationals and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION

1. Is the applicant a citizen or national of the United States? ☐ Yes ☐ No

   If the applicant is a citizen or a national of the United States, where was he/she born? _____ (city, state)

   IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D.

2. Is the applicant an amnesty alien with a valid and current I-688? ☐ Yes ☐ No
3. Is the applicant a lawful permanent resident? ☐ Yes ☐ No
4. Is the applicant a PRUCOL alien? ☐ Yes ☐ No

IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.

5. If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:

   ☐ A conditional entrant admitted to the United States before April 1, 1980
   ☐ An alien paroled into the United States, including Cuban/Haitian entrants

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- ☐ An alien subject to an Order of Supervision
- ☐ An alien granted an indefinite stay of deportation
- ☐ An alien granted an indefinite voluntary departure
- ☐ An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to volun' departure
- ☐ An alien who has properly filed an application for lawful permanent resident status
- ☐ An alien granted a stay of deportation for a specified period
- ☐ An alien granted asylum
- ☐ A refugee admitted to the U.S. since April 1, 1980
- ☐ An alien granted voluntary departure who is awaiting issuance of a visa
- ☐ An alien in deferred action status
- ☐ An alien who entered and has continuously resided in the U.S. since before January 1, 1972 who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry alien)
- ☐ An alien granted a suspension of deportation whose departure INS does not contemplate enforcing
- ☐ An alien granted withholding of deportation pursuant to INA Section 243(h)
- ☐ An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him /her, either because of the person's status category or individual circumstances.

SECTION C: VERIFICATION OF IMMIGRATION STATUS (FOR ALIENS WHO CLAIM SATISFACTORY IMMIGRATION STATUS)

IMPORTANT: Complete this section only if you answered "YES" to question 2, question 3, or question 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission (INS Form I-94) number: _____
2. Date the applicant first entered the U.S.: _____
3. Applicant's name when he/she first entered the U.S.: _____
4. Of what country is the applicant a citizen: _____
5. Where was the applicant born: _____

SECTION D: SOCIAL SECURITY NUMBER

Does the applicant have a Social Security number (SSN)? (Aliens who are not in a satisfactory immigration status, and who do not have SSN, can still get restricted Medi-Cal if they meet all eligibility requirements.)

- ☐ Yes, the applicant's Social Security number is: _____
- ☐ No

SECTION E:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant Signature:	Date:
Signature of Person Acting for Applicant	Date:

FOR COUNTY USE ONLY

EW Number: _____ County: _____ Date: _____

Action taken:

- ☐ None necessary.
- ☐ SAVE primary verification performed. _____ Date: _____
- ☐ Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS. _____ Date: _____
- ☐ Full Medi-Cal benefits were granted pending verification of immigration status.
- ☐ Copies of alien status documents are in the case file.
- ☐ Person referred to INS to obtain replacement documents. _____ Date: _____

COUNTY DETERMINATION OF THE APPROPRIATE LEVEL OF MEDI-CAL BENEFITS.

BASED ON THE INFORMATION PROVIDED ON THIS FORM:

- ☐ The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive **FULL** Medi-Cal benefits.
- ☐ The above named applicant is an alien, who, if otherwise eligible, would receive **RESTRICTED** Medi-Cal benefits.

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, ***ask your worker for help.***
5. If you need more space to answer any question, ***use Item 40.***

READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL STATEMENT OF FACTS

(Please return the completed form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are an adult applying for yourself and/or your family; (b) you, if you are a child applying for minor consent services; or (c) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you answer ***"Yes"*** to any question from 23 through 39, you must give proof. *However, if you are interested in pregnancy related benefits only, or coverage for an infant (up to age one year), you may not need to bring in proof of property. Ask your eligibility worker about the Property Waiver program.*
4. If you have a problem with any question, ***ask your worker for help.***
5. If you need more space to answer any question, ***use Item 40.***

MC 210 (5/96) INSTRUCTION SHEET–PROPOSED

STATEMENT OF FACTS (MEDI-CAL)

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

ADULT FAMILY MEMBERS

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

Social Security Number | Marital Status (check one): ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)________ | Sex: ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled: ☐ Yes, Date of Disability: ________ ☐ No | Pregnant: ☐ Yes ☐ No | Medi-Cal Requested: ☐ Yes ☐ No

2 Home Address (Number and Street) | City | ZIP Code

Mailing Address (If different from above) | City | ZIP Code

(Area Code) Home Phone ( ) | (Area Code) Work Phone ( ) | (Area Code) Message Phone ( ) | Person with whom to leave Message:

3 Spouse/Other Parent (First, Middle, Last) | Relationship to Applicant

Social Security Number | Marital Status (check one): ☐ Married ☐ Never Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated (Date)________ | Sex: ☐ Male ☐ Female

Birth Date | Is the Person Blind or Disabled: ☐ Yes, Date of Disability: ________ ☐ No | Pregnant: ☐ Yes ☐ No | Medi-Cal Requested: ☐ Yes ☐ No

CHILDREN

LIST CHILDREN AND UNBORN HERE ⬇ (Family members only. List Other People on Question 7)

4 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School: ☐ Yes ☐ No | Sex: ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled: ☐ Yes ☐ No | Pregnant: ☐ Yes ☐ No

Father's Name | Is Either Parent (✔): ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home: ☐ Yes ☐ No | Medi-Cal Requested: ☐ Yes ☐ No

5 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School: ☐ Yes ☐ No | Sex: ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled: ☐ Yes ☐ No | Pregnant: ☐ Yes ☐ No

Father's Name | Is Either Parent (✔): ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home: ☐ Yes ☐ No | Medi-Cal Requested: ☐ Male ☐ Female

6 Child's Name (First, Middle, Last) or "Unborn" | Relationship to Applicant

Social Security Number | In School: ☐ Yes ☐ No | Sex: ☐ Male ☐ Female

Birth Date or Date Unborn is Due | Is the Person Blind or Disabled: ☐ Yes ☐ No | Pregnant: ☐ Yes ☐ No

Father's Name | Is Either Parent (✔): ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Mother's Name | Child Living in Home: ☐ Yes ☐ No | Medi-Cal Requested: ☐ Yes ☐ No

DO YOU HAVE MORE THAN THREE CHILDREN? ☐ Yes ☐ No

IF YES, LIST NAME ONLY AND ASK YOUR WORKER FOR ADDITIONAL FORM(S): ________

COUNTY USE

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Case Name: ________

Case No.: ________

Worker No.: ________

Date: ________

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 & tax dep.?

☐ MC 210 S-C

☐ Potential Sneede

You may be asked to give proof and/or more detailed information on your residency, property/resources, income, c work history before your application is approved.

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	COUNTY USE
LIVING ARRANGEMENT	7 a. Is there anyone living in your home that you did not list? If Yes, list name and relationship. . . . . Name _____ Relationship_____ Name _____ Relationship_____ b. Do you pay rent for a room, apartment, house, or trailer? . . . . . If Yes, how much rent do your pay? _____			☐ MC 210S-I
	8 a. Is any family member living in a nursing home, hospital, or board and care home? . . . . . Name of person _____ Name of Home/Facility _____ Date Entered _____ b. Intend to return home?			☐ LTC return home in six months? ☐ Excess B & C Amount: $ _____
TAX DEPENDENT	9 Are you or any family member claimed as a tax dependent by a person not living with you? . . . . . Name and address of person claiming the tax deduction: _____ _____			☐ Tax dependent letter sent Date: _____ ☐ CA 2.1
RESIDENCE	10 a. Do you or any family member own, lease, or maintain a home outside California? . . . . . b. Are you or any family member currently receiving public assistance from outside California?			☐ Property ☐ PA
	11 a. Are you or any family member living outside California? . . . . . b. Are you or any family member in the United States on a Visa or a Border Crossing Card?			☐ Visa ☐ Border Crossing Card
	12 a. Are you or any family member planning to leave California for more than 60 days? . . . . . b. Do you and your family plan to stay permanently in California?			California Resident? ☐ Yes ☐ No
EMPLOYMENT QUESTIONS	13 Are you, your spouse, the other parent, or children in the home working? . . . . . List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____			☐ Under 100 hours ☐ Student Exemption ☐ If U-Parent MC 210 S-W ☐ UIB Referral
	14 Are the person(s) in 13 looking for work or more hours of work?			Redetermination: Fed Eligibility determined per MC 210 dated: _____
	15 Have you, your spouse, or other parent or any children worked in the last two years? . . . . . List Name _____ Hours Per Week: _____ List Name _____ Hours Per Week: _____			Principal wage earner _____
	16 Are you or any family member on strike? . . . . . List Name(s) _____			
RETRO	17 a. Did you or any family member have medical expenses in the last three months? . . . . . b. Does this person wish to apply for Medi-Cal coverage for those three months? . . . . . List Name(s): _____ Month(s) of Coverage: _____			☐ MC 210A Retroactive Coverage Mo._____ Mo._____ Mo._____
DED/TPL	18 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? . . . . . If yes, list name(s). _____			☐ DED Packet ☐ CA 61 ☐ SGA ☐ DED Reexamination due Date_____ ☐ Lawsuit/Hearing pending ☐ Third Party Liability
	19 a. Is disability or emotional problem expected to last at least a year? . . . . . b. Is the physical or emotional problem a result of an injury or accident?			
PA OR OTHER PA	20 Have you or any family member ever applied for or received assistance such as AFDC, Food Stamps, Medi-Cal, SSI/SSP, IHSS, transitional child care, or other benefits? . . . . . List name and what kind: _____ List where last received: _____ List when last received: _____			☐ Post MC ☐ TCC
MILITARY SERVICE	21 a. Have you or any family member ever been in U.S. military service? . . . . . Name _____ Relationship_____ Name _____ Relationship_____ b. Receiving Service connected benefits?			☐ CA 5
	22 a. Are you or any family member the spouse, parent, or child of a person who is/has been in U.S. military service? . . . . . Name _____ Relationship_____ Name _____ Relationship_____ b. Receiving service connected benefits?			

The county will determine whether or not the property/resources you or any family member have will count. Pleas include all property/resources (even for convenience only) owned, named, used, controlled, shared, held jointly wit or for other person(s).

	CHECK EACH ITEM "YES" OR "NO"	YES	NO	NAME ON ACCOUNT/ PROPERTY/RESOURCES	VALUE/ BALANCE	COUNTY USE
LIQUID RESOURCES	23 a. Savings or checking account(s)? (Banks, savings and loans, credit unions, etc.) Enter how many accounts: _____ Where: _____ Account number: _____ Where: _____ Account number: _____					☐ Current Month Income Included $ _____ $ _____
	b. IRA, KEOGH, deferred compensation, retirement account, or annuity? Enter how many accounts: _____					$ _____
	c. Cash or uncashed checks?					$ _____
	d. Stocks, bonds, certificates of deposit, money market, or mutual fund accounts?					$ _____
REAL ESTATE	24 a. A home (whether you live in it or not), other houses, ranch, land, buildings, mobile homes or life estates in or outside the U.S. or the State of California?					PR ☐ YES ☐ NO $ _____
	b. Mortgages, promissory notes, deeds of trust, or sales contracts?					$ _____
VEHICLES	25 Cars, trucks, motorcycles, trailers (any kind), off-road vehicles, recreational vehicles, airplanes, boats, campers (running or not)? Enter type and number owned: _____					EXEMPT ☐ YES ☐ NO $ _____
OTHER	26 a. Jewelry (not wedding/engagement or heirloom) worth more than $100?					☐ Pickle ($500)
	b. Household goods or personal items valued at more than $500 per item (i.e. musical instrument, personal computer)?					$ _____ $ _____ but, jointly owned ☐ separately owned ☐
	c. Mineral rights or mining claims (oil, gas, coal, etc.)?					
	d. Burial Trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items?					$ _____
	e. Trust(s) or Trust Account(s)?					$ _____
	f. Life insurance? Enter how many policies owned: _____					$ _____
	g. Long Term Care insurance?					State certified LTC policy? ☐ Yes ☐ No
	h. Other assets or resources?					$ _____
BUSINESS	27 a. Business/self-employment checking/savings account or cash?					
	b. Business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use)?					$ _____
	c. Type of Equipment: _____					$ _____
TRANSFER	28 Has anyone closed, given away, transferred, sold or traded any money, vehicles, property or other resources like those listed above in the last 30 months? If yes, complete the following:					LTC only
	☐ Transferred ☐ Sold ☐ Traded ☐ Closed ☐ Given Away					☐ Verification ☐ List Other Trans. in # 40
LIENS	29 a. Have you borrowed money against your property to pay medical bills?					Brings property within limits? ☐ Yes ☐ No
	b. Has a lien been put on any of your property as security for medical care?					☐ MC 1054 Notice to Provider
	c. Have you used any of the items in question 23 through 26 to pay for medical expenses?					

Make and Model	Year	Class Code (Registration)	Used for Transportation Yes	Used for Transportation No	Used for Self Support Yes	Used for Self Support No

Insurance Company	Policy Number	Date Policy Issued	Benefits Paid Out

Item	Date

Review your answers on questions 23–28. If you need more space to complete your answers, check here. ☐

Obtain Verif. and enter nonexempt value _____
☐ MC 210 S-P

You must complete all items in questions 30 through 33 for all members in your family including yourself.

	CHECK EACH ITEM "YES" OR "NO" → Do you or any family member get, expect to get, or has anyone applied for:	YES	NO	WHOSE INCOME	AMOUNT BEFORE TAXES	WHEN PAID/HOW OFTEN	COUNTY USE
EARNED INCOME	30 a. Money from a job (including occasional work)?..						☐ MC 210 S-W
	If yes, how many people in your home work?____						☐ Daily
	List Name _____						☐ Weekly (4.33)
	List Name _____						☐ Bi-Weekly (2.167)
	b. Expect a change in your job?.....						☐ Monthly
	(Hours or money) If yes, explain:						☐ Twice Monthly
	_____						☐ Actual
	_____						☐ Other:
							☐ Student Exempt
SELF EMPLOYED	31 Self-employed income (includes businesses, baby sitting, out-of-home sales, swap meets, arts, crafts and income from crops or other farm income)?.....						☐ Tax Statement ☐ Profit/Loss
	If yes, how many people are self-employed? _____						
UNEARNED INCOME	32 Social Security Benefits (Self).....						Use copy of award letter or check or other verification.
	Social Security Benefits (Others).....						
	Social Security Benefits (Others).....						$ _____
	Cash aid such as: SSI, AFDC, GR/GA or any other...						$ _____
	Child/Spousal Support or Alimony.....						$ _____
	Money From Friends or Relatives (include loans gifts, and contributions).....						☐ Occasional $ _____
	Railroad Retirement.....						$ _____
	Veteran's Benefits/Military Allotments.....						$ _____
	Worker's Compensation.....						$ _____
	Unemployment Benefits (Self).....						$ _____
	Unemployment Benefits (Others).....						$ _____
	Disability or Sick Benefits.....						$ _____
	Pensions, Retirement, IRA, Keogh, or Annuity Trust....						$ _____
	Interest Income, Dividends, or Capital Gain.....						$ _____
	Income From Rent, Mortgages, Promissory Notes, Deed of Trust, or Contract of Sales (including room and/or meal).....						$ _____
	Scholarships, Loans, or Grants.....						$ _____
	Income From Training Program.....						$ _____
	Name of Program: _____						☐ MC 210 S-E
	Any Other Unearned Income (Include gambling/ lottery/bingo winnings, lump sum payments, inheritance).....						$ _____ ☐ Inheritance, Insurance, etc.
IN-KIND	33 Receive ~~Rent/Housing~~, Food?..... If yes, check boxes:				Value		☐ Chart Value
	FREE / WORK FOR						☐ Actual Value
	Housing ☐ ☐				$ _____		☐ MC 210 S-I
	Utilities ☐ ☐				$ _____		
	Food ☐ ☐				$ _____		
	Clothing ☐ ☐				$ _____		

CHECK EACH ITEM "YES" OR "NO" →	YES	NO	WHO PAYS	MONTHLY AMOUNT	COUNTY USE
OTHER EXPENSES					
34 Does the self-employed person have business expenses?					☐ MC 210 S-W ☐ Verification
35 Does anyone in your home pay child/spousal support, alimony or make other payments (medical, dental, etc.) for someone who does not live in the home?					☐ Court Order ☐ Actual Payment $ _____
36 Does anyone in your home pay someone to care for a child, a disabled or elderly adult so that a household member can work, attend training or school or look for work?					☐ Dependent Care Receipts
List person(s) cared for:					☐ MFBU Member
37 Is anyone in your home a working disabled person who has medical expenses necessary to keep the job, such as wheelchair?					☐ Receipts ☐ MC 272 ☐ MC 273 $ _____ ☐ QDWI
38 Is anyone paying college or educational costs?					☐ MC 210 S-E
OTHER HEALTH COVERAGE					
39 a. Is anyone currently covered by health/dental insurance or Medicare?					☐ QMB ☐ Card ☐ SLMB
List name(s) _____					☐ DHS 6155
List name of insurance _____					☐ HIPP ☐ EGHP
b. Is health/dental insurance available through employment?					OHC CODE: _____
c. Do you or any family member have a high cost medical condition?					$ _____
d. Have your health/dental insurance stopped in the last 60 days?					☐ SSA Referral
ADDITIONAL INFORMATION					
40 Additional Information: (List any additional information for questions 1 through 39.) _____ _____ _____ _____					

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL NOT AFFECT YOUR ELIGIBILITY FOR MEDI-CAL	YES	NO	COUNTY USE
SERVICES			
41 Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given ☐ CHDP Referral
a. Do you want more information about CHDP Services?			
b. Do you want CHDP medical or dental services?			
42 Pregnant women may get help finding a doctor and transportation to see the doctor.			☐ Pregnant ☐ Parent or Guardian of child under 5.
a. Do you want to talk to someone about this help?			
b. Have you given birth within the last three months?			☐ WIC referral
c. Are you breast feeding a child?			☐ Breastfeeding ☐ Postpartum
If you answered "YES" to either b or c, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			
43 Do you want information about Family Planning Services?			☐ Family Planning Information Given
44 Do you want to talk to a social worker about other services which may be available to you?			☐ Social Services Referral
If "YES," briefly describe: _____ _____			

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant/Beneficiary			Date
Signature of Witness (If Applicant Signed With a Mark)	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Helping Applicant Fill Out the Form	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Interpreter	Telephone Number	Relationship to Applicant/Beneficiary	Date
Signature of Person Acting for Applicant/Beneficiary		Relationship to Applicant/Beneficiary	Date
Address of Person Acting for Applicant/Beneficiary			Telephone Number of Person Acting for Applicant/Beneficiary

COUNTY USE ONLY

Supplemental Forms Issued	Client Initial	Date
EW Signature	Worker Number	Date

ENCLOSURE 4

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine the Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

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IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change ~~in the citizenship/immigration~~ status of any family ~~member~~ applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

5-29-96

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.

    Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.

    Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

5-29-96

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies ... disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA reverses the denial decision and approves my SSA disability claim, my Medi-Cal will not stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disab[illegible] children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

I, _____, am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date
Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date

State of California—Health and Welfare Agency

5-9-96 ENCLOSURE 3

Department of Health Services
Medi-Cal Program

ADDITIONAL CHILDREN
(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS—MC 210)

IF YOU HAVE MORE THAN THREE CHILDREN, *LIST HERE* AND GIVE THIS FORM TO YOUR WORKER.

Every applicant asking for Medi-Cal who has a Social Security number must provide it on this form.

COUNTY USE ONLY

Case name: _____

Case number: _____

Worker number: _____

Date: _____

	Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
A Child's name (first, middle, last) or "unborn"					
B Child's name (first, middle, last) or "unborn"					
C Child's name (first, middle, last) or "unborn"					
D Child's name (first, middle, last) or "unborn"					
E Child's name (first, middle, last) or "unborn"					
F Child's name (first, middle, last) or "unborn"					

A

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No

B

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No

C

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No

D

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No

E

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No

F

Child's name (first, middle, last) or "unborn"

Relationship to applicant

Social Security number

In school ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Birthdate or date unborn is due

Is the person blind or disabled ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Father's name

Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Medical Support ☐ YES ☐ NO

☐ CA 2.1

☐ Not in home, 18–21 and tax dep.?

Mother's name

Child living in home ☐ Yes ☐ No

Medi-Cal requested ☐ Yes ☐ No